

FEB 23 1937

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF BIRTH

County *Saline*
 Township *State*
 City *State* (No. *799*)

Registration District No. *799*Primary Registration District No. *4479*File No. *4540*

Registered No. _____

St. _____

Ward _____

2. FULL NAME

(a) Residence, No. _____

(Usual place of abode)

St. _____

Ward _____

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs. _____

mos. _____

ds. _____

How long in U. S., if of foreign birth?

yrs. _____

mos. _____

ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

*Negro*5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)*married*

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OF*Downing Asbury*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

10-16-1874

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, _____ hrs.
or _____ min.*62**3**3*

OCCUPATION

8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc.*House wife*9. Industry or business in which
work was done, as silk mill,
saw mill, bank, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)*Saline Co. Mo.*

13. NAME

*Minna Pryor*14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)*Va.*

15. MAIDEN NAME

*Don't know*16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)*Don't know*17. INFORMANT
(ADDRESS)*Downing Asbury*

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Saline Mo.

DATE

*1-21-37*19. UNDERTAKER
(ADDRESS)*Hill Brothers*

20. FILED

Jan 20 1937 W.M. Tuttle

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

1-19-1937

22. I HEREBY CERTIFY, That I attended deceased from

1/18 1937 to *1/19 1937*I last saw him alive on *1/18 1937* Death is saidto have occurred on the date stated above, at *10 a.m.*

The principal cause of death and related causes of importance were as follows:

Pneumonia, lobar *1/18/37*

Other contributory causes of importance:

Name of operation

none

Date of

What test confirmed diagnosis? *Cancer*

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? *none* Date of injury _____, 19____Where did injury occur? *none*

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

none

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify

(Signed) *J. C. Giddens*, M. D.(Address) *State Mo.*

